MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

06322

Reg. Dist. No. 287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St Marys

City or town Loveville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Loveville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME J. Alice Thompson Bullock

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 30 - 1861

8. AGE: Years	Months	Days	If less than one day
83	8	7	... hrs. ... min.

9. Birthplace Loveville St Marys Maryland (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name James D Thompson

13. Birthplace St Marys

MOTHER 14. Maiden name Mary Hayden

15. Birthplace St Marys

16. Informant Mrs Richard Bullock

Address Loveville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9 1945 (month) (day) (year)

Cemetery or crematory St Joseph Cemetery

Location Mechanicsville Md

18. Funeral director W. C. Matthews Sons

Address Leonardtown Md.

19. 6/7 1945 Cancelled (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945, to June 7 1945

and that I last saw h[illegible] alive on June 7 1945

Immediate cause of death	DURATION
Cancerous, Sigmoid	2
Due to	
Due to ?	
Other conditions Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations none done

Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

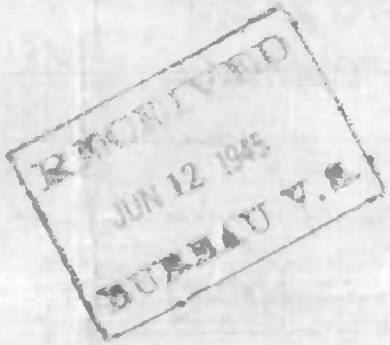
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alexius C. Wilet M. D. or other

Address Charlotte Md Date signed 6/7/45


RECEIVED
JUN 12 1945
BUREAU V.E.

Evidence for change of name see birth certificate.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

06323

Reg. Diat. No. 2 8 6

1. PLACE OF DEATH:
County: St. Mary's
City or town: Rural Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St. Mary's
City or town: Rural Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ~~Hopkins~~ Francis Aubrey Dickerson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Mar

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-1941

8. AGE: Years	Months	Days	If less than one day
	10	7	hrs. min.

9. Birthplace: Valley Md (Town, county, and state)
10. Usual occupation: none
11. Industry or business
12. FATHER — Name: Joseph Aloysius Dickerson
13. Birthplace: Md
14. MOTHER — Maiden name: Cora Estella Armstrong
15. Birthplace: Valley
16. Informant: Mrs. C. E. Armstrong
Address: Valley Md
17. (Burial, cremation, or removal. Which?) Date thereof 6-8-43 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood Md.
18. Funeral director: Thomas Armstrong
Address: Valley Md
19. 6-8-43 (Date rec'd by registrar) N. V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-7-1943, at 8:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-1943 to 6-7-1943 and that I last saw h— alive on 6-7-1943

Immediate cause of death	DURATION
Pneumonia	2 ds.
Due to: Acute tonsilitis	5 ds.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert V. Palmer M. D. or other
Address: Leonardtown Date signed 6-8-43

(M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

06324

Reg. Dist. No. 282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St Marys

City or town Drayden Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) Life

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St Marys

City or town Drayden Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Caroline Fenwick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	married

6 (b) Name of husband or wife Joseph Fenwick

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec 18 1875

8. AGE: Years 69 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Drayden St Mary's Co Md (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name William Cutchen

13. Birthplace St Marys Co

MOTHER 14. Maiden name Emily Edmonson

15. Birthplace St Marys Co

18. Informant Pearl Graber

Address 916 N Bond St Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 1945 (month) (day) (year)

Cemetery or crematory Bethesda

Location Valley Lee Md

18. Funeral director W C Matthews Sons

Address Leonardtown Md

19. 6/8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 1130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945, to June 7 1945, and that I last saw h- alive on May 1 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	4 years.
Due to Chronic Nephritis	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

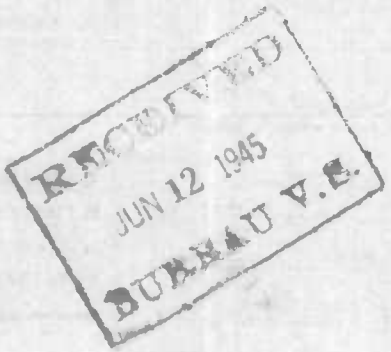
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm H Pabrick MD

M. D. or other

Address Pearson Md Date signed 6-8-45


RECEIVED
JUN 12 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-C

CERTIFICATE OF DEATH

06325

Reg. Dist. No. 282

1. PLACE OF DEATH:

County: St. Marys

City or town: Patuxent River Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

U.S. Naval Hospital

How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: Patuxent River

(If outside city or town limits, write RURAL and give nearest town)

Street No.: MCM.Q 735 C

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bonnie Sue Garretson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	S

6.(b) Name of husband or wife: Thomas Franklin Garretson

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): 26 June 1945

8. AGE:

Years	Months	Days	If less than one day
			hrs. 20 min.

9. Birthplace: Patuxent River, St. Marys, Maryland (Town, county, and state)

10. Usual occupation: New born

11. Industry or business

FATHER

12. Name: Thomas Franklin Garretson

13. Birthplace: Minneapolis, Minnesota

MOTHER

14. Maiden name: Bette Lenore Dreher

15. Birthplace: Jamestown, North Dakota

16. Informant: Thomas Garretson

Address: N.A.S. Patuxent River

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 6/26/45 (month) (day) (year)

Cemetery or crematory: Wm Lee

Location: Washington D.C.

18. Funeral director: P.B. Robinson

Address: Leonardtown Md.

19. 6/26 45 (Date rec'd by registrar) Circuler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 45, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 26 19 45, to June 26 19 45

and that I last saw h... alive on June 26 19 45

	DURATION
Immediate cause of death: Asphyxia	?
Due to: Premature birth and umbilical cord	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard Royer M. D. or other

Address: N.A.S. Patuxent River. Date signed: June 26 19 45

MB

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

06326

CERTIFICATE OF DEATH

Reg. Diat. No. 22

1. PLACE OF DEATH: St. Mary's

County

City or town: Chaptico

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: St. Mary's

City or town: Chaptico

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Edward Gregan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Joanna Gregan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12 1878

8. AGE: Years: 66 | Months: 0 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER

12. Name: James Patrick Gregan

13. Birthplace: Maryland

MOTHER

14. Maiden name: Ann Elizabeth Tippett

15. Birthplace: Maryland

16. Informant: James Gregan

Address: Chaptico Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/28/45 (month) (day) (year)

Cemetery or crematory: St. Joseph Cemetery

Location: Chaptico

18. Funeral director: Rose E. Welch

Address: Chaptico md.

19. 6/27/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 45, at 12 noon M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 19 45 to June 19 45

and that I last saw him alive on June 26 19 45

Immediate cause of death	DURATION
Carcinoma Stomach	?
Due to: —	
Due to: —	
Other conditions: Ch. Myocardial Changes.	?

(Include pregnancy within 3 months of death)

Major findings of operations: none done

Date of op.

Autopsy results: none done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clarence C Welch M. D. or other

Address: Chaptico Md Date signed: 6/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

06327

1. PLACE OF DEATH (83a)

County St Marys Registration Dist. No. 2-824

Village or City Oakville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of rasidanca in city or town where daath occurrad yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Etta Harding If U. S. Veteran, specify WAR

(a) Residence: No. St. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* tha word)
Female	Wh.	Married

5a. If married, widowad, or divorced HUSBAND of (or) WIFE of Earnest Harding

6. DATE OF BIRTH (month, day, and yaar) Apr 10 - 1883.

7. AGE	Yaars	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	11	

OCCUPATION

8. Trade, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, atc. Home Helper

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc.

10. Date decaasad last worked at this occupetion (month and yaar)

11. Total time (yaars) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) St Marys

FATHER

13. NAME George Carey

14. BIRTHPLACE (city or town) (Stata or country) St Marys Co Md

MOTHER

15. MAIDEN NAME Aniza Long

16. BIRTHPLACE (city or town) (State or country) St Marys Co Md

17. INFORMANT Mrs Minnie Davis (Address) Bald Md.

18. BURIAL, CREMATION, OR REMOVAL Place MT Zion Data June 23 1945

19. UNDERTAKER W. E. Mattingly & Son (Address) Leonardtown Md

20. FILED 6/22, 1945 Carradine Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June 21, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1944, to June 21st, 1945

I last saw h— aliva on June 15, 1945; death is said to have occurrad on the date stated above, at 9 45 Am.

The **PRINCIPAL CAUSE OF DEATH** and relatad causas of importanca were as follows:

	Date of onset
Cerebral Hemorrhage	Oct 13 1944

Dther **Contributory Causes** of importance:

High Blood pressure

Name of operation Date of

What test confirmed diegnosis? Was thera an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disaase or injury in any way relatad to occupation of decaesed?

If so, spacify

(Signed) Penn Gaskins M. D.

(Address) Bradlock Heights Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★06328

Reg. Dist. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St. Mary's

City or town Rural, Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Rural, Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Infant Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1945

8. AGE: Years — Months — Days — If less than one day — hrs. 30 min.

9. Birthplace Leonardtown, Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Calvert D. Morris

FATHER 13. Birthplace Ridge Md

MOTHER 14. Maiden name M. Elizabeth Dalton

MOTHER 15. Birthplace Leonardtown

16. Informant Calvert Morris

Address Leonardtown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17-45 (month) (day) (year)

Cemetery or crematory Our Ladys

Location Bradleys Beach Md

18. Funeral director P. B. Robinson

Address Leonardtown Md

19. 6-17-1945 (Date rec'd by registrar) P. J. Beany M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 9:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1945, to June 16 1945 and that I last saw h.. alive on June 16 1945

Immediate cause of death	DURATION
Atalectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. Beany M.D. M. D. or other

Address Great Mills Md Date signed 6-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 06331

Reg. Dist. No. 2-64

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: St Marys
City or town: Rural District
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: St Marys
City or town: Rural District
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Victoria Parks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	col	married

6.(b) Name of husband or wife: Robert Parks
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 4 - 16 - 1870

8. AGE:

Years	Months	Days	If less than one day
63	2	18	..... hrs. ..... min.

9. Birthplace: Clements (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business
12. Name of Father: Robert Vincent Dyson
13. Birthplace of Father: Clements Md
14. Maiden name of Mother: Ina Cooling
15. Birthplace of Mother: Clements
16. Informant: Rosa Curtis
Address: 1532 10th St. Washington DC
17. Burial, cremation, or removal. Which? Burial Date thereof 6-7-43 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bunkum Md
18. Funeral director: W. E. Swann
Address: Leonardtown Md
19. (Date rec'd by registrar) 6-3-43 Robt. V. Parker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 - 4 - 1943; at 1:16 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.. alive on 6-4- 1943

Immediate cause of death	DURATION
Cerebral apoplexy	Died
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert V. Parker M. D. or other
Address: Avenue Md Date signed 6-3-43

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 16329

Reg. Dist. No. 28-2

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

T

1. PLACE OF DEATH:

County: St Mary's Co

City or town: Neon Compton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3732-9th St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sylvester Donald Sunderland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8 1929

8. AGE: Years	Months	Days	If less than one day
16	3	9	hrs. min.

9. Birthplace: Washington D C (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER — 12. Name: Sylvester E Sunderland

13. Birthplace: Bristol Md

MOTHER — 14. Maiden name: Marion Wood

15. Birthplace: Bristol Md

16. Informant: Donald Custer

Address: 3529 Holmead Pl NW Washington

17. Burial, cremation, or removal. Which? Burial Date thereof 6/20/45 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Bladensburg Md.

18. Funeral director: Deal Funeral Home

Address: 4812 Georgia Ave NW Washington D C

19. 6/17 1945 Frank A. Cavaliere

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945, to 19..; and that I last saw h— alive on June 17 1945

Immediate cause of death	DURATION
Accidental drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6/17/45

Where did injury occur? Compton (City or town) St Mary's (County) Md (State)

Injured at home, farm, industry, public place (where?) Home of Leslie Cayes

Means of injury: Drowning Injured at work? No

23. SIGNATURE: Frank A. Cavaliere M. D. or Other

Address: Leonardtown Date signed: 6/17/45


RECEIVED
JUN 20 1995
BUREAU V.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

06330

Reg. Dist. No. 28 v

1. PLACE OF DEATH:

County St Marys

City or town Clements MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Clements MD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Dale Yates

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

8.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1939

8. AGE: Years 5 | Months 10 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace Clements St Marys Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Jas L Yates

13. Birthplace Clements Md

MOTHER 14. Maiden name Agnes Jane Tennison

15. Birthplace Clements Md

16. Informant Mrs Agnes J Yates

Address Clements Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1945 (month) (day) (year)

Cemetery or crematory St Joseph's Cemetery

Location Morganza Md

18. Funeral director W A Mattingly Sons

Address Leonardtown Md

19. 6/30/45 (Date rec'd by registrar) C A Camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1945 to June 29 1945

and that I last saw h... alive on June 29 1945

Immediate cause of death	DURATION
(a) Status Epilepticus	
Due to (b) Hypertrophied Tonsils	
Due to (c) Acute Tonsilitis	
Other conditions Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank A Camalier M. D. or other

Address Leonardtown Date signed 6/30/45